TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Property & Casualty Insurance Company of Hartford

MFDR Tracking Number
M4-16-0230-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THIS MEDICATION DOES NOT FALL INTO ANY OF THE CATORGORIES REGARDING PREAUTHORIZATION."

Amount in Dispute: $1494.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… Memorial Compounding has failed to explain how the use of the compound medication in this case does not qualify as an investigational experimental drug. Furthermore, Memorial Compounding has not demonstrated that it is entitled to the reimbursement requested."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30 – May 27, 2015	Prescription Medication (Compound)	$1494.45	$1494.45

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.500 defines terms used for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.530 defines the preauthorization requirements for pharmaceutical services not subject to a certified network.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization.

- 197 – Payment denied/reduced for absence of precertification/authorization.
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Is the insurance carrier's denial of payment for preauthorization supported?
2. Is the insurance carrier's denial of payment for medical necessity supported?
3. What is the total reimbursement for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed date of service April 30, 2015 with claim adjustment reason code 197 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION." 28 Texas Administrative Code §134.500 (3) defines inclusion in the closed formulary as "All available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use" excluding those that require preauthorization.

   28 Texas Administrative Code §134.530 (b)(1) states:

   > Preauthorization is only required for:
   > (A) drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;
   > (B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and
   > (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   Review of the submitted information finds that the disputed service includes a compound medication consisting of Meloxicam, Flurbiprofen, Tramadol HCl, Cyclobenzaprine HCl, and Bupivacaine HCl. The Division finds that Meloxicam, Flurbiprofen, Tramadol HCl, and Cyclobenzaprine HCl are included in the closed formulary and have a status of "Y" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary* effective on the date of service.

   The Division finds that because Bupivacaine HCl is an FDA approved drug, it is included in the closed formulary. 28 Texas Administrative Code §134.530 (d)(2) states, "Prescription and nonprescription drugs included in the division's closed formulary that exceed or are not addressed by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization." Per 28 Texas Administrative Codes §§134.500 (3) and 134.530 (d)(2), although Bupivacaine HCl is not specifically addressed by the ODG, it may be prescribed and dispensed without preauthorization.

   Therefore, because the disputed compound consists only of components included in the closed formulary that do not require preauthorization, the insurance carrier's denial for this reason is not supported.

2. The insurance carrier denied all disputed dates of service with claim adjustment reason code 216 – "Based on the findings of a review organization." 28 Texas Administrative Code §133.307 (d)(2)(I) states, "If the medical fee dispute involves medical necessity issues, the insurance carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005 of this title…" The submitted documentation fails to support an adverse determination. Therefore, the insurance carrier's denial for this reason is not supported. Disputed services will be reviewed in accordance with applicable rules and fee guidelines.

3. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:

(c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
  (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
    (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount…
  (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
    (A) health care provider

The requestor is seeking reimbursement for a compound of the generic drugs Meloxicam, NDC 38779274601; Flurbiprofen, NDC 38779036209; Tramadol HCl, NDC 38779237409; Cyclobenzaprine HCl, NDC 38779039509; and Bupivacaine HCl, NDC 38779052405. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
4/30/15	Meloxicam	(194.67 x .18 x 1.25) + $4.00 = $47.80	$35.04	$35.04	$0.00	$35.04
4/30/15	Flurbiprofen	(36.58 x 4.8 x 1.25) + $4.00 = $223.48	$168.72	$168.72	$0.00	$168.72
4/30/15	Tramadol HCl	(36.30 x 6.0 x 1.25) + $4.00 = $276.25	$168.00	$168.00	$0.00	$168.00
4/30/15	Cyclobenzaprine HCl	(46.332 x 1.8 x 1.25) + $4.00 = $108.25	$80.37	$80.37	$0.00	$80.37
4/30/15	Bupivacaine HCl	(45.60 x 1.2 x 1.25) + $4.00 = $72.40	$46.02	$46.02	$0.00	$46.02
5/14/15	Meloxicam	(194.67 x .18 x 1.25) + $4.00 = $47.80	$35.04	$35.04	$0.00	$35.04
5/14/15	Flurbiprofen	(36.58 x 4.8 x 1.25) + $4.00 = $223.48	$168.72	$168.72	$0.00	$168.72
5/14/15	Tramadol HCl	(36.30 x 6.0 x 1.25) + $4.00 = $276.25	$168.00	$168.00	$0.00	$168.00
5/14/15	Cyclobenzaprine HCl	(46.332 x 1.8 x 1.25) + $4.00 = $108.25	$80.37	$80.37	$0.00	$80.37
5/14/15	Bupivacaine HCl	(45.60 x 1.2 x 1.25) + $4.00 = $72.40	$46.02	$46.02	$0.00	$46.02
5/27/15	Meloxicam	(194.67 x .18 x 1.25) + $4.00 = $47.80	$35.04	$35.04	$0.00	$35.04
5/27/15	Flurbiprofen	(36.58 x 4.8 x 1.25) + $4.00 = $223.48	$168.72	$168.72	$0.00	$168.72
5/27/15	Tramadol HCl	(36.30 x 6.0 x 1.25) + $4.00 = $276.25	$168.00	$168.00	$0.00	$168.00
5/27/15	Cyclobenzaprine HCl	(46.332 x 1.8 x 1.25) + $4.00 = $108.25	$80.37	$80.37	$0.00	$80.37
5/27/15	Bupivacaine HCl	(45.60 x 1.2 x 1.25) + $4.00 = $72.40	$46.02	$46.02	$0.00	$46.02

4. The total reimbursement for the disputed services is $1494.45. The insurance carrier paid $0.00. A reimbursement of $1494.45 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1494.45.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1494.45 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	November 3, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.